Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HARRIS METHODIST FORT WORTH
PO BOX 916063
FORT WORTH TX 76191

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-06-2511-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Trauma DX Codes Reimbursed at 75%."

Amount in Dispute: $10,361.66

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and/or reduced to fair and reasonable. All reductions of the disputed charges were made appropriately."

Response Submitted by: ACE American Insurance, S. Rhett Robinson, FOL, 504 Lavaca, Suite 1000, Austin, TX 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
May 13, 2005 through May 15, 2005	Inpatient Services	$10,361.66	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401(c)(5)(A), effective August 1, 1997, 22 TexReg 6264, requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate.
3. 28 Texas Administrative Code §134.1, effective May 16, 2002, 27 TexReg 4047, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as

described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission."

4. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. This request for medical fee dispute resolution was received by the Division on December 8, 2005. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 Texas Register 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 22, 2005 to send additional documentation relevant to the fee dispute as set forth in the rule.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 112-003-The primary provider is a non-contracted provider with Focus.
   - 885-999-Review of this code has resulted in an adjusted reimbursement.
   - 975-410-Copy of provider's invoice used to determine reimbursable amount.
   - 975-640-Nurse review in-patient hospital/facility bill.
   - F-Fee guideline MAR reduction.
   - 45-Charges exceed your contracted/legislated fee arrangement.
   - 5-The procedure code/bill type is inconsistent with the place of service.
   - 900-Based on further review, no additional allowance is warranted.
   - 981-Reviewed by Medical Director.
   - W1-Workers Compensation state fee schedule adjustment.
   - W4-No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. According to the explanation of benefits, the carrier paid the services in dispute in accordance with the FOCUS network. The network reduction amount on the submitted explanation of benefits dated August 26, 2005 denotes a $0.00. The respondent did not clarify or otherwise address the "45" claim adjustment code upon receipt of the request for dispute resolution, nor was documentation provided to support that there is a contract between the provider and the FOCUS network. For these reasons, the Division finds that the "45" claim adjustment code is not supported.
2. This dispute relates to inpatient surgical services provided in a hospital setting with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 816.02. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. 28 Texas Administrative Code §133.307(g)(3)(B), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted documentation finds that the requestor has not provided copies of all medical records pertinent to the services in dispute. Although the requestor did submit a copy of the operative report, the requestor did not submit a copy of the anesthesia record, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(g)(3)(B).
4. 28 Texas Administrative Code §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
   - The requestor's rationale for increased reimbursement from the *Table of Disputed Services* asserts that "Trauma DX Codes Reimbursed at 75%."
   - The requestor did not discuss or explain how it determined that 75% of the amount billed would yield a fair and reasonable reimbursement.
   - Documentation of the amount of reimbursement received for these same or similar services was not presented for review.

- The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former Acute Care Inpatient Hospital Fee Guideline, which states at 22 Texas Register 6276 (July 4, 1997) that:

  "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

  Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	10/14/2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.